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ABSTRACT

A case study of psychiatric intervention for two sisters whose brother is dying of leukemia is presented. The therapeutic technique attempted to deal with the threatened loss by a forthright approach to the reality situation, encouraging "immunizing" discussions, allowance for catharsis without severe regression, emphasis on reality orientation, and direct initiation and enhancement of mourning through the use of transference materials. A theoretical discussion of the capacity of children to mourn is included. Am empirical assessment of the therapy suggests that immediate ventilative help at a time of great stress was provided, but that there was little effect on the children's capacity to sustain prolonged mourning processes. (DP)

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PREVENTIVE THERAPY WITH SIBLINGS OF A DYING CHILD

Daniel Feinberg, M.D.*

Although the literature on childhood parental bereavement has been steadily growing in recent years (Furman, 1964; Gautier, 1965; Harrison, et al, 1967; Hilgard, et al, 1960; Mahler, 1961; Shambaugh, 1961; Wolfenstein, 1966), there has been little written regarding reactions of children to the death of a sibling. Nor has there been much of an attempt to define or refine techniques for preventive therapeutic work with this population. The purpose of this paper is: (1) to show through a clinical study of the treatment of two sisters what difficulties and rewards accrue from brief therapy for the purpose of helping children adapt to a sibling's dying and death, (2) to suggest a general therapeutic approach, and (3) to add further insight into the theoretical question of the capacity of children to mourn.

CASE HISTORY

Barbara and Carol R. were the seven-and-a-half and nine-and-a-half year old sisters, respectively, of Charles, who at the time initial contact was made, was six years old and had been diagnosed as having leukemia at age four-and-one-half. Charles himself had been involved for the previous year in intensive psychiatric treatment[1] at the same facility.[2] Although his presenting symptoms had been regressive transvestite behavior, considerations of his disease and fatal prognosis had been quite directly worked on with his therapist.[3] Doubtlessly, a positive institutional transference enabled the mother to more readily involve her daughters in a psychological preparation for their brother's death.

Both sisters were emotionally relatively healthy and symptom-free children who were performing adequately in school and in their peer relationships. However, the fact that the children's father, from whom she was divorced three years previously, was soon moving to Denver, thus depriving the children of his frequent and regular contacts, possibly further prompted Mrs. R. to seek supportive help for them. An additional impetus was that Carol had developed a transient symptom of pilfering from family members two years previously, shortly following Charles' initial hospitalization. This symptom disappeared after a few visits with another therapist.

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[1]For a description, see Psychological Emergencies of Childhood, Gilbert Kliman, M.D., Grune and Stratton, New York, 1968, pp. 26-43.

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A different episode occurring shortly before treatment started convinced Mrs. R. that the potential for renewed symptomatology in Carol was high again. The family had been riding together in the car and Barbara had mentioned how far they had been traveling, to which Carol had responded, yes, indeed, if they kept traveling much longer they could even get as far as Colorado. Minutes later, when confronted by Barbara with this thought, Carol completely denied having had it, and could not believe what she had said. Thus, separation and loss, the father's move to Colorado, produced conflict and repression, and certainly resonated with another predictable loss, that of Charles.

The children's previous history revealed that Carol was by far the father's favorite. From birth onward, he had quite openly made so much more of his oldest child, especially through a close physical relationship, that it was apparent to friends of the family and relatives alike. This bias was strong enough even after the divorce to cause him to spend more time talking with Carol than with any other family member when he telephoned. Barbara and Charles were closest to each other and, not surprisingly, Mrs. R. felt closer to them and experienced most of her difficulties with Carol. These were not, however, of serious magnitude, and were initially verbalized by the mother as a difficulty in "getting to" Carol, irritation with her frequent whining or refusals to respond to maternal requests, an increased frequency of crying, and a recent drop in school performance. The mother was equally as irked at the father's lack of interest in his son, including his apparently blasé attitude about Charles' illness and hospitalizations, an attitude which continued throughout the latter's life and after his death, including the period of acute grief for the rest of the family.

At the time of our initial contact with the girls, Charles was physically symptom-free, and the frequence of his psychotherapeutic sessions had been decreased to once weekly. Mrs. R. had had regular counseling contact with Charles' therapist and thereby had gained considerable support in coping with both her feelings and the vicissitudes of mothering a dying child. Although her denial was present in varying degrees to the end, she frequently openly discussed Charles' impending death with me during the ten month period that I was seeing her daughters. Each sister was seen by the author separately and weekly, with few exceptions, from a period roughly eight months prior to Charles' death until two months following it. The mother was also seen by the author every two weeks for support and guidance.

TREATMENT[4]

Although diverse aspects of each girl's treatment are of interest, such as maturational and developmental differences in the capacity to sustain the affect of sadness, or the nature of grief in children, I wish to concentrate on the technical aspects of therapy, inasmuch as this has not been discussed in detail elsewhere. I will not discuss my guidance of Mrs. R.

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[4]I wish to thank Dr. Gilbert Kliman for his helpful suggestions regarding this portion of the paper.

Suffice it to say that she had been as well prepared for her son's death as could be hoped for and mainly required an opportunity for ventilation.

For heuristic purposes I have artifically divided the therapeutic approach into five widely overlapping categories, with the intent of focusing in detail on some specific interactions which I think contributed most to the liberation and working through of feelings. These are: (1) an immediate and persistent attempt by the therapist to establish a therapeutic alliance based on forthrightness; (2) the stimulation and encouragement of 'immunizing' discussions; (3) the encouragement and allowance for catharsis without severe regression; (4) emphasis on reality orientation; (5) direct initiation and enhancement of mourning, using transference material wherever possible.

Forthrightness

One of the more difficult problems any physician or psychotherapist faces in dealing with a dying patient or members of his family may be expressed as the question: "Should I or should I not tell the truth?" Difficulty in resolving this question always contributes to poor handling of the patient. However, a readiness to tell the truth imparts to the patient or family the knowledge that when they wish to let themselves "know" it, they will be honestly supported by the physician. Too many doctors feel that they must be active and "tell." On the contrary, if the physician can equally accept the idea that it is the patient's task to "ask," even if it is, as it most often is, indirectly, he will be guided by the latter's pace in denying or accepting and will thus be able to respond more sensitively.

A readiness to tell the truth, moreover, helps to establish an emotional climate of trust between a therapist and child in which sad facts are imparted and shared as much by feeling as by words. In fact, at no time in these children's treatment did either of them ask me if their brother would die, although both consciously knew it early (if not prior to therapy) as the material will abundantly show. Ideally, the major problem must remain the patient's acceptance and not the doctor's conveyance. Success with both presupposes the physician's ability to accept fully his own helplessness in the face of incurable diseases.

In the initial sessions I actively sought to establish an attitude of directness and honesty without severely threatening defenses. Neither child was allowed to maintain that they didn't know why their mother had brought them to see me. Each eventually associated in her first session to their brother, and my response was to establish immediately with them a dialogue about the physical nature of his illness. For the first month or two, Carol was more openly concerned with separation from her father, but indicated an understanding of the purpose of her visits in the first session when, while telling me about Charles' second hospitalization, she quoted him as having said on his return home that it had not been as bad as the first "Because he had to get hurt in order to get helped." Perhaps she was unconsciously sensing the nature and direction of our work together.

Barbara started therapy several weeks after Carol. In fact, therapy was initially considered only for the latter. But considerable anxiety was precipitated in Barbara by two minor crises: Charles was unexpectedly rehospitalized for several days and, during that time, both sisters witnessed their pet dog, Candy, being fatally hit by a car. Although Barbara's initial communications were to build big and small buildings with blocks, experimenting to see if the big buildings would fall over on the small ones, thus heralding a theme which continued to be important to her--the idea of Charles' growing up tall and her guilt over her previous aggression toward him--I did not immediately comment on this theme, but directed her attention instead toward the purpose or task of our sessions. She first resisted these attempts, but then told me about her brother's hospitalization and the death of their dog. In the early sessions I encouraged both girls to express their understanding of Charles' illness and indicated my appreciation that it was only partly understood by them, as well as my willingness to go into it more with them as they became more ready to do so. I did not have to be as direct with Carol who, I felt, better understood the purpose for assistance, but something more specific was required with Barbara. After she said it was "Something like the white cells eat the red cells," she clearly indicated by her silence that she did not want to talk more about it. I reflected to her how difficult it was to talk about this, and maybe that was why Mommy brought her to see me, because sisters of boys who have a serious sickness in their blood have worries about it, and are not sure what is going to happen. Mommy must have felt that I could help them by letting them talk or play and by explaining some things to them.

In the early weeks, there were other opportunities to consolidate an atmosphere of truthfulness. When Carol referred to Charles as being "unlucky" if he would not be able to take a vacation with his sisters and father that month, I added quite gratuitously, "He is unlucky about a lot of things." Several weeks later, in recounting to me how she had learned from her mother about Candy's death by euthanasia at the Vet's, Carol mentioned two different injections on succeeding days, which led to some confusion on my part:

> I wondered whether or not the vet had put him out of his misery with the first shot and she said no, she wasn't told that. I said that sometimes even doctors don't tell children the truth, to which she responded that it was not a matter of a <u>doctor's</u> telling the children, that this is what he had told her mother, who had told them.

Both of these comments were made with the intent to establish an expectable approach from me. I believe that this encouraged the following exchange to occur with Carol during the fifth month of therapy:

> Carol told me about the deaths of various of their pets and more specifically of Barbara's cat who had died suddenly the previous year and had been buried at night in the rain by Mommy. At first Mommy had come in and told everyone that it had gotten lost, but one day when she was alone with Carol and Charles, Mrs. R. admitted to them that Timmie had died and had not run away. Carol observed that

> Mommy had originally told them a lie because she was afraid that Barbara would have gotten very upset. She noted that when her mother finally admitted the truth to Barbara, her sister got upset anyway and started to shout and scream that Mommy should have told her. At this point I said to Carol, "It's a funny thing, isn't it, Carol, that grownups sometimes can't tell children the truth because they are afraid that it will hurt the children." She nodded in affirmation and immediately verbalized my own next thought: that Barbara would have gotten less upset if she had known right away. I agreed.

Immunizing Discussions

Theoretically, a primary object loss can be more easily experienced affectively in a displaced fashion such as through discussions of the previous deaths of pets or of people outside the primary family, as well as through freeing up and interpreting the unconscious or preconscious references to any less overwhelming loss situations in the patient's present life. In this manner via verbalized associations, the primary object can be repeatedly cathected and decathected, in a gradual and low energy fashion. Although this may occur autonomously in most instances without therapeutic intervention, persistent stimulation of such a process should achieve a more intense and frequent reworking of affects.

For instance, in the above discussion with Carol about the value of telling the truth to children, which stemmed from a rather lengthy exchange on the various house pets who had died and been buried in the backyard, she mentioned that she had known that the cat was sick for a couple of days beforehand, because it was "sleepy and didn't move around as much as before." (This was her almost verbatim description of her brother just prior to his most recent hospitalization). When she then associated to her goldfish and told me that once at Barbara's birthday party her mother told her that her goldfish had died, I asked her how she had felt, and she screwed up her face and said that she didn't feel as bad as she did about her cat "Because Nips was bigger." With my encouragement she elaborated upon this by saying it was also because "You can do more with a cat or a dog than a goldfish." I agreed that a cat or a dog are closer to being a friend than a fish. Her later associations that session were of a reproachful nature toward her sister for her aggressive play with Candy shortly prior to the dog's fatal accident. This latter theme was echoed in a later session when Carol openly criticized Barbara's aggressive play with Charles.

More immediate sadness was experienced following Candy's death. After describing Charles' hospitalization to me, she associated to her dog and described with sadness, fighting back tears, how he had run out into the street while the kids were playing and gotten hit by a car. In the same session her associations led to the possibility of her moving alone to live with her father, her rejection of that idea, and then to tearful memories of the university he'd left, asking me if I'd ever been there and had I found it a pretty campus, too. She even wondered if I knew

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of a specific building and described it to me in detail at my bidding.

A most poignant example of how affects can achieve gradual liberation occurred with Barbara during Charles' final hospitalization, a few weeks before his death. Just preceding one of her sessions, Charles had taken a turn for the worse, and when during the week one of the girls complained of not being able to go anywhere anymore, their mother had told them that what they were going through now would last for only a short time and that that might be all the time that Charles had left, and that they should be able to stand it. In the session, Barbara immediately conveyed her concern about being taken by surprise:

> Barbara refused to take off her coat, telling me when I asked her about it that when she and Carol go to her aunt's house, sometimes as soon as Carol takes off her coat her mother tells them that it's time to go. . . She told me her cat wasn't eating. . . and associated to Candy and to her pet gerbel who had been accidentally killed when the cat knocked over the box. . . Then she categorized for me all the animals who were buried in her backyard, at one point actually getting off the chair to show me graphically where in relation to the house her cat's grave was. (I was reminded of this behavior about a month later when she again got off her chair to map out for me the relationship of her brother's grave to a tree that was planted nearby.) She added that she had learned from Carol where in the backyard the grave was, that her mother hadn't told her about it. She then said with emphasis that she was glad that her <u>mother</u> had buried him. I surmised that she meant that it would have been too hard for her to do it and she said, "Yes," and became depressed.

There were other times when, for the briefest moment, Barbara's strong defenses gave way to appropriate affect. She had been harboring an almost unmanageable amount of sadness and anxiety following Charles' critical deterioration and during the session she was in a hypomanic state with flighty associations, hyperactivity, jesting and imitation of TV commercials. The only association she allowed herself to her brother was one that occurred while I was talking with her sister. She had gone across the street with her mother to buy a get-well card for Charles with a sad looking dog on it. The inscription was: "I've been living a dog's life since you've been away--running after cars." In her own session, Barbara's association to this was: "Like Candy," her affect saddening ever so briefly, and then she took off quickly to another subject, despite my efforts to encourage more thoughts about it.

Carol struggled lengthily with anxiety about separation and aloneness evoked by the thought of death. In early discussions of this, there was a facilitation of her ability to face the finality of death. The following exchange offered a choice of responses by the therapist. I might have responded to the idea of separation, but chose instead to encourage Carol to give up the vestiges of her animistic concept of death:

> . . . Carol was talking about the cremation of one of their cats, telling me she didn't like that idea, that it was "nicer"

to be buried. I wondered why and she said she wouldn't like to be buried if she died. I asked her if she thought she would know the difference, and she said no, but it was nicer for dogs to be put in the ground next to other dogs. I asked her if she thought the buried dog would know the difference, and she said with a smile and in a tone of voice that conveyed to me that she knew better but wanted to tenaciously deny it, "Maybe they would know the difference." She then added that she thought that people also should be buried next to each other.

Allowance for Catharsis

Secondary to the immediate concerns of permanent separation and loss aroused by a sibling's dying, the shift of attention by the parents to the sick child causes anger and resentment on the part of the well children, who may be too narcissistic to accept their relative abandonment with grace. If not effectively dealt with, aggression and subsequent guilt, or regressive yearnings for the unavailable parents lead to symptoms or acting out, as in Carol's case two years previously. However, the regressive defenses of siblings might prove more difficult for parents than such a transient acting out, especially since they receive impetus from the expectable regressiveness of the sick child himself and represent a less well externalized solution to their conflict. Thus, one of the goals of therapy would be to allow for as full a catharsis as possible, but in a controlled manner, where both the intellectual and emotional sharing within the therapeutic dialogue substitute in some part for the temporarily absent parent.

Anger and resentment were much more prominent in Carol, who, because of her stronger attachment to her departed father, and her more ambivalent relationship with the mother, was left more vulnerable to any deprivation. On the other hand, guilt related to previous aggression toward Charles was much more evident with Barbara.

The first time I broached the subject of her mother's being away from home so much when Charles was ill in the hospital, Carol had great difficulty in talking about it, but after some minutes of denial was able to tell me that she and Barbara did wish mother to be with them when she is away so much because they got lonely for her. Although the girls were adequately looked after by a few reliable neighbors and relatives, Carol felt herself abandoned. She talked about Charles pleading with mother to stay in the hospital so much that he once wanted mother "to come home for dinner." I called her attention to this slip and although she rationalized it, I followed this with a sympathetic confrontation that it was hard for sisters of somebody that was sick because parents had to spend a lot of time with the child. She made no response to this. I then asked her if she knew why Charles wanted to have mother there with him so much. She said she didn't know, and when I encouraged her to tell me what she could imagine or guess, she said with more insistence and with a slight whine to her voice, that she just didn't know.

In a subsequent session about a month after this, Carol described her mother's busy schedule during the eleventh hospital day of Charles' next-to-last hospitalization. Mother would come home late, and as soon as she got home the phone would ring and then she would be lost to callers for the rest of the evening. Later in that session, when I had occasion to comment that her brother must have been in pain over the weekend that he had been admitted to the hospital, her immediate response was that her grandmother makes it worse, that her grandmother behaves "almost as if she was Charles." This was in part a displacement and externalization of the feeling that she herself could make it worse on the family situation with complaints. After she described how the grandmother's constant complaining made things worse, I echoed her thought that complaining is what Charles does, too, and she agreed. I said that when children get sick, they usually do complain or cry more than usual because they want their mother to pay more attention to them. Carol agreed that that's exactly what Charles always wants to do with mother. I said that that was another thing that made it really hard when brothers were sick, not only because mothers had to spend time with them, but because the sick children make the mothers spend more time with them and the sisters get angry when this happens because they can't have much time with mother themselves.

Although this clarification and interpretation of her anger led to an immediate change of associations, she was able to return later in the session to the difficulty she had in planning things because of her mother's commitment in the hospital. At this point, I chose to go farther than I expected her to be able to come of her own accord. I reminded her of the previous talk about anger, and said that sometimes the children who aren't sick feel that their anger might make the sick brother even sicker. She said that Barbara gets angry with Charles even when he is sick; and I acknowledged that I knew that this was so. But I then added that sometimes children who are angry in this way even have a wish that the sick brother wasn't there anymore, that it was all over and they could have mother back again. Carol's expression immediately changed. She became quite depressed and looked downward, avoiding my eyes. I followed this by saying that children usually felt this way and there was nothing bad or wrong with it. She still did not respond, but listened as I explained further that the reason it was not wrong was that at the same time that they had that feeling they still loved their brother and wanted him to get better. I added that maybe it sounded like a funny thing that someone could have two opposite feelings about just one person at the same time, but that they really could. She remained silent for the minute until the end of the session, at which time she asked me for a clarification of the alternation of her sessions with Barbara's, a request probably related to her anxiety whether or not, now that I had verbalized her hostile wishes toward Charles, I still found her worthwhile and planned to continue with her.

Barbara shared some of her sister's resentment toward Charles' regressions. In describing for me the difficult weekend he had prior to hospitalization, she referred to his complaining of pains in his head, saying: "At least that's what he said." She also achieved a good deal of catharsis in relation to her feelings of loss, specifically angry feelings. In repeated sessions she built tall buildings and knocked them over, and

indicated she was "angry" at a building when it fell apart. She once associated from such play to a broken toy car, and then to the old unused car that was still in their driveway, which they weren't going to get rid of because: "Carol and I still like it."

Probably the fact that therapy not only allows for communication of feelings, but also encourages a child to "stay with" feelings over an extended period of time, is a constructive ego experience. It is possible, for instance, that the encouragement to tolerate feelings in general, whether anger, resentment, or loneliness, can have the specific effect of increasing a child's tolerance for sadness, too.

A good example of how catharsis with very little interpretation can lead to a better choice of defenses was evidenced in a session with Carol:

> Charles had just taken a turn for the worse and was on the critical list, and mother rather than a neighbor had brought Carol to the session for the first time in a long while, telling me that she felt it important to take some time off from the continual vigil with Charles to be with the girls. I initiated the session with a remark that this was the first time in a long time that mother had come, which led Carol to tell me that it was because Charles now had a full-time nurse. I responded that that must mean that he was very ill, which was met with denial and the assertion that it was just so that mother could have more of a chance to spend some time with her and Barbara. We discussed the difficulties her mother had in spending time with them and Carol wondered, in a whining voice, what would happen, for instance, if she herself got sick at the same time. Then she developed the theme: How would mother divide her time between the two? She supposed mother would alternate weekly. That's because visiting hours would be the same time. She didn't know how mother would solve that problem. I suggested that mother would have to find a way, but added that it would be harder for her than for most mothers because her family was different: right now there was only one parent nearby, so that there couldn't be one parent for each sick child. She brightened at this and remembered that her father had mentioned he would come East especially if Charles got sick, he promised. But this quickly gave way in turn to repeated speculation as to whether or not his job would release him because of "very important business" he had there. When I suggested that her Daddy also would have to make a choice in such a case, she wondered what if he had to stay out there with a sick cousin of hers, especially if her aunt and uncle were away. I said it seemed as if she wasn't really sure who her Daddy or Mommy would think to be more important. At this she became quite depressed and remained silent for a few minutes. . .

Carol's thinly disguised wish to regress, to get sick, is evidenced. Her being able to experience the depression first was necessary to her subsequent intellectualized, but more successful defenses:

> . . . She broke the silence by noting some dead moths in a light encasement on the ceiling, wondered how they got there, and how they died. She said if she were a bug she would be smart enough not to do that, adding that if she were a bug, knowing what she does now, she'd be able to avoid dangerous lights and fly swatters that kill bugs, and thus survive.

Thus, Carol expressed a repudiation of the wish for some harm to befall her so that she might get her mother's love and attention. By the end of the session she was talking of her intent to become a scientist who could be smart enough to figure out cures for all sicknesses, an active and sublimated defense against the wish to be passive, sick, and cared for.

This preparation allowed Carol and her mother to have a very valuable interchange on the day Charles died. Following a brief period of catharsis shared with each other, her mother berated herself for having pestered Charles the entire previous night to keep sitting up in bed so he could breathe better. Carol admonished her not to feel guilty about it, noting that when she herself is doing something wrong, she would rather have her mother scold her than not have her there at all. Although Carol could afford now to be more generous about her mother's time, it was nonetheless impressive that she was able to alleviate the latter's guilt with such a rare insight into the importance of a mother's closeness with a dying child, something which might not have been possible had her previous resentment not been as well expressed.

Reality Orientation

Although reality-orientation is a sine qua non of most psychotherapies, I have in mind something quite specific affecting both the initiation of and the carrying through of the work of mourning. Very conscious efforts by the therapist to detail the course and pathology of an illness, the child's perception of the patient's clinical symptoms, as well as an orientation to the correct chronology of the upsetting events surrounding it, should contribute to a more reality-oriented attitude toward the death itself. Confusion and ambiguity have a way of being contagious, and mourning cannot effectively occur when a child is burdened by misconceptions, misperceptions, and fantasies. Moreover, some understanding by a child of the emotional responses of others--that is, of the dying sibling and the parents--to the illness, also contributes to a more complete understanding of events and thus to the reality of the situation. Unless there is "ground breaking" at the level of the basic facts of the illness, there can be no solid foundation upon which the child can work with the therapist to accept the most threatening fact, that of death. Success presumes that there are not only conscious and purposeful attempts by the therapist to stimulate such an orientation by direct questioning, but a complete sharing of information at the child's level of comprehension.

Thus, a considerable amount of time was spent setting into correct chronological order the vicissitudes of Charles' illness and hospitalizations. Understandably, because of maturational limitations, this was less successful with Barbara, although not necessarily less useful to

her. It included not only eliciting from each child her own understanding of the disease, but clarifying the misconceptions and offering explanations for the various experiences that their unique situation had exposed them to. For instance, there were the blood tests and spinal taps that Charles was subjected to, the talk that they heard about various new drugs, the references made by their mother to trying different hospitals and treatments. In addition, by asking them to tell me about the observable changes in Charles' physical status, they were being forced not to avoid that reality, which made repression and denial more difficult. Theoretically, in terms of any future mourning work to be done, full memories or mental images might thus be more available to them, less vague and shadowy. This sharpening of focus on the inner and outer representations of the lost object contributes to greater ease of cathexis prior to subsequent decathexis.

Witness the following description by Carol of her brother following a visit with him after not having seen him for several weeks:

> He was skinnier, his hair was shorter. . . his eyes looked like they were out. . . they really weren't out, but they looked bigger.

Perhaps the notion that it was all right to observe, or possibly that it was even good or helpful to observe, in part led to Carol's subsequent insistence that she be allowed to view Charles' body in the casket at the funeral home. She described to me how he seemed different, somewhat darker in complexion, blown up and with large empty places for eyes. She told me that her mother had agreed to let them take Charles' eyes to give to somebody else. I said that it wasn't the entire eye, that it was only part of it. Carol pointed to her own eyes and said, "Yes, the cornea." She continued that he didn't look like the Charles she had known, and I reminded her that he even was changed when she had seen him alive for the last time a few weeks before. She said, "It still was different, even different from then." I said to her that this time he was very still, and she said sadly, yes, he was.

For Barbara the problems of reconstructing impressions and events of importance were more difficult because of her stronger avoidance. However, there were times when I felt that this reconstruction took precedence over other aspects of the work, such as her expression of anxiety about abandonment. An example of this occurred the day following Charles' death, when she indirectly expressed her relief about being back with mother in her comments about a certain part of a child's story book in which a steamshovel puts a little lost bird back into its nest. I chose not to respond to this communication but rather to press her for details about her learning of Charles' death, her having gone with her mother to choose the gravesite, and her having seen her brother in the casket. The chief rationale for forcing this material was to lessen the unreal or dreamlike quality a traumatic event is likely to have in retrospection. It also may allow the child to exert some mastery by actively recounting his memory of it.

Initiation of Mourning

If a therapist is able to define as an aim of the treatment work the remembering of a lost object, whether the memories are happy or sad, and especially if he can make use of transference manifestations of feelings about loss and separation, spontaneous remembering may be facilitated in children. Aside from the previously noted material where mourning occurred in a more displaced fashion through discussion of losses of objects other than their brother, I attempted to create an atmosphere wherein these children would not only understand my purpose in reviewing memories, but would feel that there was a good reason to share them with somebody.

There was a difference in their respective abilities to form a therapeutic alliance on this specific issue. Barbara's immaturity led to stronger avoidance and suppression than her sister, while Carol gave concrete evidence that to her the notion was consciously recognized as useful, even if painful. It was introduced to her in the following way:

> Carol was depressed and silent for a good part of the session, at no point exchanging more than one or two thoughts at a time. She mentioned briefly their having gotten a new cat, and I said that it was to replace Candy, and she agreed. I asked her if she ever thought about how it used to be with Candy and she said she did. I was interested about these thoughts but she shook her head as if to say she really didn't know. I said to her that people do think about pets that have died, sometimes for a long time after the pet is gone, and it helps them get over having lost it. I said that if they remember from time to time, it's easier than trying to remember all at once, which might be too upsetting.

The development of this definition continued until as late as the session three days prior to her brother's death.

> Carol started the session by talking about the nice cat she had drawn while waiting. She debated about naming it, decided on "Charlie" and said she'd give the picture to her brother. . . She talked about a desire to live forever and said she would not like to die. I asked her why, but she seemed stuck for an answer. I asked her to imagine what she thought it would be like. Was it scarey? Would it hurt? She said it wouldn't hurt, it was just funny, and then she finally grasped the words she was searching for: "You can't talk to people you used to talk to!" I agreed that this concern about aloneness was what bothered children about death and that being alone is one of the hardest things for children. Her immediate thought was that people who are left behind can talk about you, but would forget you probably. I said there are ways that people had to keep from forgetting someone who died and asked her if she knew how, and she thought for a while but said she didn't. Then, after a short silence, she said that it was hard to remember and do your school work at the same time. I said that was right, but sometimes when children

didn't have school or didn't have work to do they would have time to remember the memories they had about somebody they used to love who had died. Carol commented about a girl friend of hers whose grandmother was ill and about to die. She said that she won't be sorry when her own grandmother dies because she was old and has led a good life. I said we could understand that a little because it was much sadder when a young person, who hasn't had a chance to live a full life died. Carol then began to talk about how difficult it was to let go of feelings, specifically angry feelings, and that sometimes she lets them build up inside, and then she has to kick the wall. Sometimes she asks Barbara, who gets her angry, to leave the room so she can kick the wall, so she won't kick Barbara. I said this was similar also to people having trouble letting go of their sad feelings by crying, and then Carol commented that it wasn't good to let them build up inside, that she could get sick that way. Then there was a minute or two of silence, after which I asked her if she knew any more ways people remembered others, and she said she didn't. I said sometimes they visit the grave at the cemetery, whereupon she immediately stated that she couldn't do that, she wouldn't do that. I asked why not, and she said because when you went there you couldn't see the person anyway. I said that was true, but that when people did go to the grave, it made them feel a little bit closer to the memories that I had been talking about, it made the memories a little bit easier to come back. I then told her that there was another way that dead people are remembered, and that was that sometimes children were named after them. She immediately responded with eagerness to this, and talked about her hopes that their pregnant cat would have enough kittens so that they could name each kitten after a member of the family.

One week later, after her brother's death, Carol asked her mother why her father hadn't shown any signs of grief over Charles' death by sadness or crying. Her mother explained his difficulty in having deep feelings in general. Thus, the previous therapeutic work probably allowed her to appreciate the inappropriateness of her father's inhibition, and moreover to separate herself from this pathological adult response. She thereby avoided ambivalence or uncertainty about which parent to identify with in grief.

Because of her age, it was more difficult for Barbara to allow herself the same freedom as her sister to experience deep feelings of sadness and loss. Therefore, it became all the more important to make use of the therapeutic relationship both to induce and share these feelings by interpreting them in the transference. For instance, Barbara was totally unable to describe any feelings she had at the funeral. Her description of the day was: "It was cold." She said nothing about her brother and nothing about relatives crying, but reported fragmented factual data instead, such as the number of clergymen in the front of the church, or that the funeral limousine had electric windows. In contrast,

Carol could talk about the sad people and admit to having felt sad during the day (although she allowed that she could not remember if this feeling lasted for the following day) before drawing four brightly colored renditions of the four seasons, telling me when I pointed out the brightness: "Mommy's still sad."

However, there was an opportunity the evening before the funeral to help Barbara express her sad feelings:

> She entered in a constrained mood, sober but not terribly sad. She was dressed like her sister in a brightly colored dress and a gay straw bonnet. With much questioning on my part, she told me how her mother had broken the news of Charles' dying to them, of their trip to the cemetery, and her having briefly looked at her brother at the funeral home. At the end of the time I indicated that we would have to stop and that I would be seeing her again soon, but she did not budge. I quietly said good night to her but she lingered in her chair fingering a book. After a moment of silence I said to her that tomorrow she and her sister and mother would be saying goodbye to Charles and when somebody who you loved very much died and you had to say goodbye to them, all kinds of saying goodbye were hard. I said it was even hard for her to say goodbye to me tonight. She didn't move and remained quietly and sadly in the chair. We talked a few moments more about crying and she told me that she had cried later in the day after the news and that she had been thinking of Charles when she did. I told her that some goodbyes, like this one, can take a long time, and that sometimes children remember a brother for a long time and may even cry when they think of him. After this, only with a good deal of hesitation, she was finally able to leave.

The final phase of therapy continued for two months following Charles' death. During this time, on repeated occasions, Carol was able to <u>initiate</u> painful remembering with her family. Her mother reported to me that she had spontaneously expressed her own sad feelings, with tears in her eyes, reminding them that it had been ten days since her brother's death and that it didn't seem that long. Once, returning from a weekend away from home, she said she did not want to go back to their house house because all of Charles' things were in the house and reminded her of him, but a day or so later asked her mother to help her sort through several bags of toys and paraphernalia that had been returned from the hospital. During a session at this time, she told me their house was "too familiar," that they could get rid of all Charles' things but that wouldn't help because whatever they did they would remember him, and then further added that wherever they went where they had ever been with him they would remember him too. She told me of some photographs that had been taken the previous year and I encouraged her to bring them in so I could see them, which she did a week or so later, although she was not at all saddened as we looked at them and seemed most concerned that she had come out poorly in one of them. On another occasion, she told me with some brightness in her voice about the possibility that

they would get a dachshund, Charles' favorite dog. Later she said that she doesn't cry anymore (this was a month after the funeral) and doesn't know why, and that she doesn't think she could cry even if she wanted to. She admitted to getting a little bit sad. She said her Mommy told her that grownups get sadder than children and that the older they are when someone dies the more they cry. However, on the first month anniversary Carol asked her mother if they could visit the cemetery. In the final sessions, she talked about wishes for a special kind of teddy bear, the kind with a big head and small body. She would get a baby one "because they live longer." She talked of wanting to take a cuddly bear to bed with her and of her desire to have a real live one cling to her. Her denial persisted:

> I commented that even a young teddy bear could die and she wondered how and I asked her what she thought. She said he could get hit by a car if he ran out in the street. I said, "just like your dog, Candy." She agreed. I wondered if there were other ways and she said she supposed it could get sick to which I agreed. Then she said: "I never knew that could happen to young animals."

In her final session she epitomized a child's need to turn away from death:

> I said she was remembering how hard it had been when mother had been going to the hospital and was with Charles all the time, and added that in a way her Mommy still was with Charles. She seemed puzzled, as if she didn't understand and then said she didn't, so I asked her if she could think of a way. She paused for a moment or two and said: "Yes, maybe if she's thinking a lot about him." I agreed and added that it was different with grownups, who let themselves feel sadder for a longer time. Her response was that that was true, that children have a lot of friends, that they can just go outside and play.

In contrast, Barbara seemed to her mother to remember Charles in a matter-of-fact way with an entirely neutral affect. She regressed and became provocative, testing, and teasing. She behaved with Carol exactly the way she had with her brother. Whereas Carol told her mother she "liked" to talk about her brother, and reminisced frequently, Barbara didn't. While Carol's thoughts turned to replacing Charles with a baby, (at one point she asked her mother to have a baby brother or to adopt one) Barbara expressed no such thoughts at home, and only once in her sessions:

> Barbara was recounting with delight having cheated Charles at Checkers. Her associations led to the idea of crying and this led to a discussion wherein she said she "thinks" she still might get sad about him. Then she reported a dream about Candy with a lot of puppies. I interpreted her wish to replace her brother in order to alleviate her sadness, following which she became momentarily depressed.

It was harder work to get to her sad affect in the sessions. If she were talking about different sets of girl twins that she knew, I would remind her that now she and Carol were very much more like twins, whereupon she became sad. Or she would talk about her favorite colors and say that she was glad that things were not in black and white, and I could direct our thoughts to funeral clothes and to reminiscences of what people wore to funerals. In her last session, I pointed out to her that her persistent interest in the events on the street outside the office window was her way of not wanting to be interested in what was happening inside and that it had started right after Charles had died:

> She became quite depressed in response to this and more so when I further pointed out how hard it was for children to look at what was happening inside themselves because it might hurt a lot. At this point she began to relate one memory after another about her brother, finally describing to me how the neighborhood kids had trampled down some of Charles' flowers recently, killing all of them, and, saddening a little as she recollected, added that the flowers would probably grow out again because the seeds were still in the ground. She would plant an onion and watch it grow. I reflected to her about how nice a wish it was that Charles' flowers grow back again or that people could also grow back again, or be alive again just the way the flower might. She immediately corrected me and said, "No, not like a flower, like a tree." I said that maybe one of the reasons she wanted to grow that onion, was her way of expressing her wish that Charles could have kept on growing as tall as a tree and didn't have to stop. She said: "I never thought of it like that before."

DISCUSSION

The question as to whether mourning was facilitated for these children first requires a clarification of the concept of childhood mourning. Some investigators, notably Wolfenstein (1966), feel that children are not capable of the sustained or prolonged experiencing of sad and angry feelings that adults, in the course of normal mourning, allow themselves to have. Bowlby (1960) discusses childhood mourning in three stages, but skirts the issue as to whether or not this particular protest followed by despair and resignation accomplishes for the child what the intermittent reworking of memories of the lost object does for the adult. Fleming and Altschul (1963) find in retrospective studies via the psychoanalyses of neurotic adults bereaved in childhood that invariably there is a strong fixation in the transference at roughly the age of the patient's bereavement. Still other observers believe that a major obstacle that stands between healthy children and the ability to grieve and mourn is adult unsupportiveness and denial--parental and professional--that children can have deep feelings (or that they can tolerate them). Kliman (1968), for example, has taken the position that what is

often sufficient to allow a healthy child to mourn is an opportunity to be helped in a supportive and encouraging way to gradually express these feelings.

I am inclined toward Wolfenstein's opinion that mourning requires the previous normal passage through adolescent object decathexis as a necessary "trial period" in order to autonomously decathect later lost love objects. She would not likely consider Carol's behavior true mourning, but rather a healthy childhood response to object loss (perhaps we should seek to differentiate "childhood mourning" from "adult mourning"). With both children there was an immediate transferring of freed libido onto new objects, with a tendency to try to relive the old relationship in real life rather than in conscious remembering.

Barbara showed a limited extratherapeutic response to her brother's death, rarely spontaneously speaking of him with sadness, and relaying almost entirely on the work of therapy to be able to do so. The strength and persistence of her defenses, notably ego regressions, transient hypomanic moods, and avoidance, indicate how great is a younger child's need to avoid affects in such situations. Her crying together with her mother and sister immediately following the news of Charles' death was part of a shared grief response. Also, Carol's limited ability to revive spontaneously memories of her brother could be explained on the basis of a positive identification with the therapist, who consciously encouraged and guided her in this direction. Indeed, if one also considers the mother's unusual capacity to show them her own sadness and grief, it is likely that Carol's "autonomous" response was based largely on identification with her adult objects. Inasmuch as both children in their sessions repeatedly experienced deeply sad feelings following interpretations, something which a child of eight or ten might not achieve on his own, one must wonder how importantly this immediate help with affects contributed to their long-term adaptation to their brother's death.

A brief ten-month contact with both sisters suggests a preliminary answer. Carol had been getting along better with her mother at this time. She was proud of the latter's having a job, was herself doing very well in school, and was generally in a pleasant frame of mind and much less preoccupied with joining her father. She once had asked her mother if she had children when she grew up whether or not they could have leukemia. Barbara felt "abandoned" by mother's working, and was continually losing things that tended to thwart her efforts in school (homework notes, eyeglasses, etc.) Also, she had frequent complaints about vague illnesses such as stomach aches, although there was no evidence of a morbid somatic identification with her brother's illness. As far as the children's having mentioned their brother was concerned, it was "as if he had never existed." Their mother felt as if both girls had "pulled the curtain down" at the mention of his name. Carol once tearfully admitted to missing him following a fight with her mother in which the latter first admitted that she was upset about remembering Charles. Both girls were reluctant for anyone to know they had had a brother who died. This was attested to by the fact that all their new friends' parents were surprised and shocked when months subsequently they learned of the event from Mrs. R. The only positive evidence of a continuing "mourning" process was Carol's occasional requests to visit Charles' grave. In the follow-up

sessions with me, neither girl talked of Charles, and both withdrew somewhat when I mentioned his name. Both were reluctant to discuss their memories.

Thus, although in their therapy repeated sadness was induced, there was little evidence of continued conscious painful remembering in either girl without direct help from adults. Instead, immediate object substitution in the form of wishes for new pets or a baby brother occurred. In this respect, the follow-up revealed an interesting and ironic occurrence. Within two weeks of Charles' death, Mrs. R. bought a dog which Charles himself had indicated a desire for when he had seen it at a dog show. The girls gave it the same name as Charles had wished for it. Three months later Carol returned home from school in a hurry to watch a TV show, accidentally let the dog out of the house, and when she did not immediately attempt to retrieve him, he was hit and killed by a car. Carol showed little remorse about the incident, although she talked about the accident daily for about two weeks.

What, then, was accomplished with these children? If indeed the therapy was unable to prevent an unfortunate unconscious repetition of a traumatic event closely related to fraternal death, what was prevented?

First, the frequently timely and appropriate induction of sadness, as well as the sharing of it with an adult ego in a way that made it more tolerable, must have had importance to the child's psychic economy. For instance, Carol noted in her remarks about anger that the result of damming up too much feeling would be an explosive discharge. The gradual liberation of both the anger and the sadness probably prevented untoward defenses against such an event.

Attention to importa[illegible]eality details during a confusing, threatening, and deprived time mi[illegible]re mitigated some common sequelae of object loss in childhood, name[illegible] perceptual distortions, cognitive inhibitions and disturbances in the child's sense of reality.

Confrontations or interpretations of their anger, jealousy or sense of abandonment, feelings which are universal in such situations, could not have been made in as timely or effective fashion by even the most well-counseled parent, not to mention the extra burden this would have imposed on a grieving adult who is not a neutral interpreter. In this latter respect, skilled use of transference material relating to cessation of therapy or to the ending of sessions can be most helpful in evoking a more conscious awareness by the child of his feelings about separation and death.

SUMMARY

Brief therapy of two sisters of a dying child is presented. The therapeutic technique attempts to deal with the threatened loss by a forthright approach and attention to details of the reality situation. "Immunizing" discussions and allowance for catharsis without regression are encouraged.

Finally, transference material is interpreted where it relates to object loss and is likely to induce sad affects.

An empirical assessment of the therapy suggests that there was considerable immediate ventilative help at a time of great stress, with prevention of secondary behavioral complications or an outbreak of neurotic symptomatology. A brief ten-month follow-up suggests that such supportive therapy, although it may help in the immediate manifestation of feelings, has little enduring effect on a child's capacity to sustain a prolonged mourning process. Perhaps the long duration of their brother's illness allowed anticipatory mourning to occur. In any event it is difficult without a more comprehensive study to be certain of the significance of the observed ten-month period of minimal mourning activity.

Finally, I have not attempted to deal with three important implications of the material: (1) What influence the suddenness or protractedness of dying has on grief and mourning; (2) How grief differs in the event of parental bereavement as opposed to sibling bereavement; and (3) What constitutes normal as opposed to abnormal "childhood" grief or mourning? These questions and related ones require further study and a receptivity on the part of the profession for preventive intervention with all bereaved children, symptomatic and asymptomatic alike.

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